STATEMENT OF EMERGENCY

907 KAR 3:125E

(1) This emergency administrative regulation is being promulgated to enable the Department for Medicaid Services to impose service limitations, including limits on the number of chiropractic visits, in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. Additionally, this emergency administrative regulation establishes the use of clinical criteria by the Department for Medicaid Services to determine the appropriateness of any given care.

(2) This action must be taken on an emergency basis to ensure the viability of the Medicaid program in conjunction with 907 KAR 1:900E. .

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation except that the emergency regulation explicitly states August 1, 2006 as the effective date for establishing clinical criteria pursuant to 907 KAR 3:130 for authorization purposes. The effective date is inappropriate for the ordinary administrative regulation given that it will not be adopted by August 1, 2006.

_____
Ernie Fletcher
Governor

_____
Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Physician and Special Services

(Emergency Amendment)

907 KAR 3:125E. Chiropractic services and reimbursement.

RELATES TO: KRS 312.015, 312.017, 42 CFR 440.230, 441 Subpart B, 42 USC 1396d(r)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, Public Law 109-171 [~~EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to chiropractic services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy and amends coverage in accordance with Public Law 109-171.

Section 1. Definitions. (1) "Chiropractic service" means the diagnosis and the thera

peutic adjustment or manipulation of the subluxations of the articulations of the human spine and its adjacent tissues performed by, and within the scope of licensure of, a licensed chiropractor in accordance with KRS 312.015 and 312.017.

(2) "Chiropractor" is defined in KRS 312.015(3).

(3) "Current procedural terminology code" or "CPT code" means the identifying code used by the department for reporting a medical service or procedure.

(4) "Department" means the Department for Medicaid Services or its designated agent.

(5) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130. [~~means that a covered benefit shall be:~~

~~(a) Provided in accordance with 42 CFR 440.230;~~

~~(b) Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;~~

~~(c) Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;~~

~~(d) Provided for medical reasons rather than primarily for the convenience of a recipient, caregiver, or provider;~~

~~(e) Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;~~

~~(f) Needed, if used in reference to an emergency medical service, to evaluate or sta-~~

~~bilize an existing emergency medical condition that is found to exist using the prudent layperson standard; and~~

~~(g) Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B for eligible recipients under twenty-one (21) years of age.~~

(6) "Usual and customary charge" means the uniform amount that a medical provider charges to a private-pay patient or third-party payor in the majority of cases for a specific medical procedure or service.

Section 2. Covered Services. (1) A covered chiropractic service shall include the following:

(a) An evaluation and management service;

(b) Chiropractic manipulative treatment;

(c) Diagnostic X-rays;

(d) Application of a hot or cold pack to one (1) or more areas;

(e) Application of mechanical traction to one (1) or more areas;

(f) Application of electrical stimulation to one (1) or more areas; and

(g) Application of ultrasound to one (1) or more areas.

(2) A chiropractic service shall be covered:

(a) If medically necessary;

(b) Effective August 1, 2006, if clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

(c) Except as specified in Section 3 of this administrative regulation, [~~a medically-necessary chiropractic service shall be covered~~] to the extent[~~,~~] and subject to the ser-

vice and reimbursement limitations[,] that the same service is covered by the department for a physician.

(3) A chiropractic service [and] shall be reported using:

(a) An evaluation and management CPT code;

(b) A chiropractic manipulative treatment CPT code;

(c) A diagnostic X-ray CPT code; or

(d) Physical modality application CPT codes for the following:

1. Application of a hot or cold pack to one (1) or more areas;

2. Application of mechanical traction to one (1) or more areas;

3. Application of electrical stimulation to one (1) or more areas; and

4. Application of ultrasound to one (1) or more areas.

(4) Unless a recipient's health care provider demonstrates that chiropractic services in excess of the following limitations are medically necessary, coverage of chiropractic services shall be limited to:

(a) Fifteen (15) chiropractic visits per year for a recipient age twenty-one (21) years and older; and

(b) Seven (7) chiropractic visits per year for a recipient under twenty-one (21) years of age.

[(3) Coverage for a chiropractic service shall be based on medical necessity.]

Section 3. Prior Authorization. (1) Prior authorization from the department shall be required for reimbursement of a covered service, specified in Section 2(1) of this administrative regulation, for each chiropractic visit, including any additional visit beyond the service limitation established in Section (2)(4) of this administrative regulation. [pro-

~~vided during a chiropractor-recipient face-to-face contact with the same provider occurring after the initial twelve (12) contacts. If there has been an interval of at least six (6) months since the last chiropractor-recipient face-to-face contact with the same provider, up to twelve (12) additional chiropractor-recipient face-to-face contacts shall be reimbursed, if medically necessary, without prior authorization from the department.~~]

(2) A chiropractor shall request prior authorization by mailing or faxing the following information to the department:

(a) A completed Kentucky Form MAP-810, Chiropractic Prior Authorization Form; and

(b) If requested by the department, additional information required to establish medical necessity.

Section 4. Reimbursement for Covered Services. (1) A charge for a chiropractic service submitted to the department for payment shall not exceed the usual and customary charge to a private-pay patient or third-party payor for an identical procedure or service.

(2) For reimbursement of a covered service, a chiropractor shall be paid the lessor of the chiropractor's usual and customary actual billed charge or an amount determined in accordance with the physician fee schedule established in 907 KAR 3:010.

Section 5. Conditions for Provider Participation. A participating chiropractor shall:

(1) Be licensed as a chiropractor in Kentucky or in the geographic location in which chiropractic services are provided;

(2) Have an active Medicare provider number; and

(3) Meet the requirements for provider participation in the Kentucky Medicaid Program in accordance with 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673.

Section 6. Appeal Rights. (1) An appeal of a negative action taken by the department

regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 7. Incorporation by Reference Material. (1) "Ky. Form MAP-810, Chiropractic Prior Authorization Form, September 26, 2000 edition," is incorporated by reference.

(2) The material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 3:125E

REVIEWED:

Date	Shannon Turner, J.D., Commissioner Department for Medicaid Services
Date	Mike Burnside, Undersecretary Administrative and Fiscal Affairs

APPROVED:

Date	Mark D. Birdwhistell, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:125E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502-564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes coverage provisions related to chiropractic services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish chiropractic service coverage.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation allows for payment to be made under the Medicaid program for services that are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent that Medicaid pays for the same services provided by a physician.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation allows Medicaid coverage of chiropractic services provided by a licensed chiropractor in accordance with KRS 205.560.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment establishes limitations on the amount of chiropractic services such that reimbursement is available for no more than: fifteen (15) chiropractic visits per year for a recipient age twenty-one (21) and older; and seven (7) chiropractic visits per year for a recipient under age twenty-one (21). However, chiropractic visits beyond the service limit may be approved if medical necessity is demonstrated by a recipient's health care provider through the prior authorization process. These actions are being taken in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. Additionally, the amendment establishes the use of clinical criteria to be used to determine the appropriateness of any given care.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to maintain the financial viability of the Medicaid program and is being enacted in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. Additionally, the amendment is necessary to attempt to ensure the appropriateness of care.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment establishes chiropractic service limitations as authorized by the Deficit Reduction Act of 2005 and approved by the Centers for Medicare and Medicaid Services. These actions are being taken in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. Additionally, the amendment conforms by attempting to ensure the appropriateness of care.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by limiting chiropractic service coverage in order to maintain the financial viability of the Medicaid program. These actions are being taken in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility

for individuals with mental retardation or developmental disabilities level of care needs. Additionally, the amendment will assist by attempting to ensure the appropriateness of care.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients in need of chiropractic services and chiropractic providers will be affected by this amendment.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: Recipients will be subject to a limited number of chiropractic visits per year unless their health care provider demonstrates that additional visits beyond the service limitation are medically necessary. These actions are being taken in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
   (a) Initially: The Department for Medicaid Services (DMS) anticipates significant annual savings as a result of this amendment; however, the precise amount is indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.
   (b) On a continuing basis: DMS anticipates significant annual savings as a result of this amendment; however, the precise amount is indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an

amendment: No increase in fees nor funding will be necessary to implement the amendment to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

Tiering by age group was applied in conjunction with 907 KAR 1:900E (KyHealth Choices Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs.